

## *Assessment and recommendations*

Norway combines a unique mix of a favourable economic and labour force situation and very high investments in education and health with a pervasive exclusion of people with health problems from the labour market. While the Norwegian system has generated a high and stable employment rate over the last decades, one-fifth of the population receives income supports due to health problems, and spending on disability and sickness benefits amounts to around 5% of GDP, by far the highest level in the OECD. The causes for this combination cannot be found either in a lack of vocational rehabilitation policies or a lack of elaborated support structures; both are well developed. Rather, the reasons lie in a political reluctance to revise a very generous social protection system; to implement effectively far-reaching changes introduced in the past decade; and to enforce new obligations rigorously.

### **Blocking the exclusion perspective**

For many people with a mental disorder, the welfare-driven strategy has the contrary effect of exclusion and inequality: people with a severe mental disorder have a nine-fold unemployment rate compared with the national average and, more generally, Norwegians with a mental disorder did not benefit from the favourable labour market situation in the period leading up to the recent crisis, as reflected in falling employment and rising unemployment rates for this group. Relatively easy access to long-term or permanent work incapacity benefits not only plays to some typical characteristics of mental illness like, for instance, fear avoidance, withdrawal and passivity, but also isolates people with mental disorders from the world of work.

To improve labour market access and job retention of people with a mental disorder, perspectives should be changed. Employees with a mental health problem are more frequently taking long-term sick leave compared with people with a physical health problem, and their sickness rates have steadily increased, despite an elaborate system of sickness absence monitoring. Similarly, the drop-out rate of clients with a mental disorder

from vocational rehabilitation programmes is high despite a strong work-first approach and a broad range of supports over several years. Finally, disability benefit claims are seldom rejected and, once awarded, rarely reassessed, although beneficiaries with a more moderate mental disorder typically have a fluctuating work capacity. To improve the effectiveness of existing measures, the perspective of long-term sick leave and permanent disability benefit should in many cases be blocked from the beginning.

### **Matching responsibilities and funding structures**

Responsibility for sickness and disability benefits is very unequally distributed, with the bulk of the costs covered by social insurance. Employers have a key role in preventing sick leave and supporting the return-to-work process, but are financially involved in short-term absences only, reducing their efforts to avoid harmful long-term sick leave. Employees also face limited incentives to avoid sickness absence, receiving compensation equal to 100% of their previous wage for up to one year. Co-workers represented by their unions, and the physicians' certification behaviour also influence workplace dynamics and return-to-work, but unions and doctors do not bear any of the financial costs of their decisions. Finally, the municipalities – responsible for health, education and rehabilitation services – have much impact on the rates of exclusion, but are not involved in health-related work incapacity funding either. Although it is difficult to quantify the responsibility of each actor, new ways of co-financing should be discussed to improve their commitment to labour market inclusion of people with mental ill-health.

### **Reconsidering sickness absence policies**

Norway has, by far, the highest rate of sickness absence in the OECD. Despite a recent focus on partial sickness leave, full-time sick leave is still the rule. General practitioners (GPs) are responsible for sickness certification, but they find it difficult to assess the duration, degree and future development of functional capacity. Sickness absence regulations are quite elaborate but there is no early identification of sick leaves due to mental illness. Medical and vocational professionals come in too late in the process, if at all, and the elaboration of a return-to-work plan is left to the employer and the employee. Managers and human resource professionals are not trained sufficiently to identify and intervene in mental health problems. The strong focus of existing services such as occupational health services or the labour inspection authority on sickness prevention and health promotion, results in a lack of targeted early intervention and support to employers.

## **Revising disability assessment procedures and eligibility criteria**

The eligibility criteria for a disability benefit are strict in Norway requiring a permanent loss of work capacity and excluding social problems or milder mental disorders. Nevertheless, common mental disorders like mood and neurotic disorders are the main reason for a disability benefit in people with mental health problems, especially in older age. The strict eligibility rules do not always seem to be followed. Moreover, around one-third of the new beneficiaries have never sought treatment for their mental health problem. The possibility to receive a disability benefit after several years of vocational rehabilitation undermines the seriousness of the integration efforts. Another potential problem lies in the disability assessment process itself, which is influenced significantly by the claimants; often takes place without the involvement of a mental health specialist; and lacks a focus on periodic reassessment.

## **Improving the outcomes of vocational rehabilitation**

The many different vocational rehabilitation services in Norway support an increasing number of clients. However, education and training are still the most frequently used measures despite a modest effectiveness, and they are used mostly as re-education measures for persons with higher education rather than to up-skill people with low education. Conversely, wage subsidies to employers, which are rather effective, are hardly used. Finally, the large group of people at risk of dropping out of the labour market but still at work is not reached by vocational rehabilitation. The existing employer support centres could offer a basis for support to employees struggling in work provided these centres would be expanded; turned into multidisciplinary services; and given responsibility for individual follow-up.

## **Strengthening health care integration**

The disintegration of mental health care and employment services, as well as the fragmentation within the mental health system itself with municipal primary care and regional specialist care, is a main barrier for labour market inclusion. The pioneering Norwegian strategy for work and mental health has tried to build a bridge between the Labour and Welfare Administration (NAV) and the health care sector. In order to yield sustainable improvements, however, structural measures are needed. For instance, the few insurance physicians in the NAV offices are not allowed to see the claimants; when in treatment, the significance of the patient's employment situation is undervalued; and many people on sick leave have an undetected mental disorder indicating a need for improved co-operation between general and specialist care. A more integrated approach is also hindered by a lack of inter-sectoral routine data. Finally, while people with a

severe mental disorder and more generally all those who can afford private psychotherapy seem to have good access to mental health services, the majority of people with moderate disorders and working problems have long waiting times for psychiatric treatment.

Due to the early onset of most psychiatric disorders and the importance of a good education for future performance in the labour market, mental health problems in pupils should be tackled in concerted action. This would be important because non-completion of upper secondary education is common in Norway, especially in apprenticeships. There are a number of obstacles: pedagogical and psychological services are not obliged to cooperate with health services; general health services often do not refer young patients to specialists; and teachers do not receive enough support. In case of inward-oriented mental disorders not associated with difficult behaviours or emotions, the chance to get specialist treatment is low. Finally, there are no services and no integrated concepts to systematically secure a successful and sustainable transition to work.